# *Product/Benefit Comparison Grid Summary*

| | HealthSelect | CIGNA | | | | |
|---|---|---|---|---|---|---|
| | | A. HMO | B. POS | | C. PPO | |
| | In-Network Services Only | In-Network Services Only | In-Network Services | Out-of Network Services | In-Network Services | Out-of Network Services |
| **Standard Benefit Coverage** | | | | | | |
| Deductible | | | | | | |
| Individual | None | None | None | $300 | $250 | $750 |
| Family | None | None | None | $600 | $500 | $1,500 |
| Standard Coinsurance Percentage Covered by | None | None | None | 70% after deductible | 80% after deductible | 60% after deductible |
| Out-of-Pocket Maximum for Specific Services | | | | | | |
| Individual | None | $1,000 OOP maximum for inpatient and outpatient surgery copayments | $900 OOP maximum for inpatient and outpatient surgery copayments | $3,000 OOP maximum | $2,000 OOP maximum | $4,000 OOP maximum |
| Family | None | $2,000 OOP maximum for inpatient and outpatient surgery copayments | $1,800 OOP maximum for inpatient and outpatient surgery copayments | $6,000 OOP maximum | $6,000 OOP maximum | $12,000 OOP maximum |
| Lifetime Maximum Benefit | Unlimited | Unlimited | Unlimited | $5,000,000 | Unlimited | $5,000,000 |
| Pre-existing Condition Limitation | None | None | None | 12 months waiting period; creditable service months may decrease the period | 12 months waiting period; creditable service months may decrease the period | 12 months waiting period; creditable service months may decrease the period |
| **General Services** | | | | | | |
| Preventive Care | $5 Copay | $10 Copay | $15 Copay | Covered in-network only | 80% after deductible | Covered in-network only |
| Primary Care Physician Services | $5 Copay | $10 Copay | $15 Copay | 70% after deductible | 80% after deductible | 60% after deductible |
| Specialty Care Physician Services | $5 Copay | $10 Copay | $25 Copay | 70% after deductible | 80% after deductible | 60% after deductible |
| Lab and X-Ray | No Copay | No Copay for lab or x-ray; $50 Copay for MRI & CAT | No Copay for lab or x-ray $50 Copay for MRI & CAT | 70% after deductible | 80% after deductible | 60% after deductible |
| Outpatient Surgery | No Copay | No Copay | $100 Copay | 70% (Prior authorization required)* after deductible | 80% after deductible | 60% (Prior authorization required)* after deductible |
| Urgent Care Facility (Participating) | $5 Copay | $35 Copay | $50 Copay | 70% after deductible | $50 Copay | 60% after deductible |
| Emergency Room (Copay Waived if Admitted) | $50 Copay | $75 Copay | $100 Copay | $100 Copay if emergency, otherwise 70% after deductible | $100 Copay | $100 Copay if emergency, otherwise 60% after deductible |
| Ambulance | No Copay | No Copay | No Copay | No Copay | 90% after deductible | 90% after deductible |
| **Inpatient Hospitalization** | | | | | | |
| Facility Services | No Copay | No Copay | $100/day $300 maximum per admission | 70% (Prior authorization required)* after deductible | 80% after deductible | 60% (Prior authorization required)* after deductible |
| Physician & Surgeon's Services | No Copay | No Copay | No Copay | 70% (Prior authorization required)* after deductible | 80% after deductible | 60% (Prior authorization required)* after deductible |
| Penalty for Not Getting Prior Authorization | NA | NA | NA | $400 Penalty | $400 Penalty | $400 Penalty |
| **Maternity** | | | | | | |
| Prenatal & Postnatal Exams | Copay waived after 1st visit | Copay waived after 1st visit | Copay waived after 1st visit | 70% after deductible | 80% Coinsurance after deductible for first visit, then 100% | 60% after deductible |
| Hospital Delivery | No Copay | No Copay | $100/day $300 maximum per admission | 70% after deductible | 80% after deductible | 60% after deductible |

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| | In-Network Services Only | In-Network Services Only | In-Network Services | Out-of Network Services | In-Network Services | Out-of Network Services |
| **Equipment & Devices** | | | | | | |
| Durable Medical Equipment | No Copay | No Copay ($3500 maximum) | No Copay ($3500 maximum) | Covered in-network only | 80% after deductible ($700 Maximum) | 60% after deductible ($700 Maximum) |
| External Prosthetics & Orthotics | No Copay | No Copay ($1000 maximum) | No Copay ($1000 maximum) | Covered in-network only | 80% after $200 deductible ($1,000 maximum) | 60% after $200 deductible, ($1000 maximum) |
| **Outpatient Rehabilitation** | | | | | | |
| Physical, Speech, & Occupational Therapy | $5 Copay | $10 Copay | $15 Copay | 70% after deductible | 80% after deductible* | 60% after deductible* |
| Chiropractic Services (No referral required; visit limit is per calendar year; chronic care not covered; must be medically necessary). | $10 Copay<br>12 visits | $10 Copay<br>20 visits | $15 Copay<br>20 visits | Covered in-network only | 80% after deductible** | 60% after deductible** |
| Benefit Limit per Calendar Year | 60 Visits for therapies (not including chiropractic care) | 60 visits (includes therapies & chiropractic care) | 60 visits (includes therapies & chiropractic care), in-network & out-of-network combined | 60 therapy visits, in-network & out-of-network combined | *60 therapy visits, in-network & out-of-network combined<br>**Unlimited chiropractic visits | |
| **Other Healthcare Facilities** | | | | | | |
| Skilled Nursing Facilities | | | | | | |
| Subscriber Payment | No Copay | No Copay | No Copay | 70% after deductible | 80% after deductible | 60% after deductible |
| Limit per Contract Year | 20 days per illness | 90 days combined | 90 days combined | 90 days combined | 90 days combined | 90 days combined |
| Home Health Care | No Copay when medically necessary (unlimited) | No Copay when medically necessary (unlimited) | No Copay when medically necessary (unlimited) | 70% after deductible; up to 40 days per year | 80% after deductible (unlimited) | 60% after deductible; up to 40 days per year |
| **Family Planning** | | | | | | |
| Sterilization | | | | | | |
| Vasectomy | Place of Service Copay | Place of Service Copay | Place of Service Copay | 70% after deductible | 80% after deductible | 60% after deductible |
| Tubal Ligation | Place of Service Copay | Place of Service Copay | Place of Service Copay | 70% after deductible | 80% after deductible | 60% after deductible |
| Infertility Services | Not Covered | Diagnostic Services and Corrective Treatment Only | Diagnostic Services and Corrective Treatment Only | Covered In-Network Only | Diagnostic Services and Corrective Treatment Only | Covered In-Network Only |
| **Dependent Children** | | | | | | |
| Child must be unmarried and legally dependent upon employee and/or spouse. | Covered to age 19 unless full time student and then covered to age 25 | Covered to age 19 unless full time student and then covered to age 25 | | | | |
| **Pharmacy Benefit** | **HealthSelect** | **Walgreens Health Initiatives** | | | | |
| Out of Pocket Maximum | None | $1,500 Individual; $3,000 Family | | | | |
| Retail | $5.00 Copay for Generics | Tier 1 Generics: 25% Coinsurance; $2 Minimum; $10 Maximum | | | | |
| | $15.00 Copay for Brand | Tier 2 Brand Name (Preferred): 30% Coinsurance; $5 Minimum; $25 Maximum | | | | |
| | | Tier 3 Brand (Non-Preferred); 30% Coinsurance; $20 Minimum; $50 Maximum | | | | |
| Retail Supply | 30-day supply | 30-day supply (available at any contracted pharmacy) or 90-day supply (available at Walgreens Pharmacies) | | | | |
| Mail Order | $15 Copay for Generics | Tier 1 Generics; 20% Coinsurance; $6 Minimum; $28 Maximum | | | | |
| | $30 Copay for Brand | Tier 2 Brand Name (Preferred); 25% Coinsurance; $15 Minimum; $70 Maximum | | | | |
| | | Tier 3 Brand Name (Non-Preferred); 25% coinsurance; $60 Minimum; $140 Maximum | | | | |
| Mail Order Supply | 90-day supply | 90-day supply | | | | |
| **Behavioral Health Benefit** | **United Behavioral Health** | **United Behavioral Health** | | | | |
| **Vision Benefit** | **AVESIS Vision Plan** | **AVESIS Vision Plan** | | | | |
| **Note: Lifetime Maximum and Visits per calendar year for Out-of-Network Services, cross-accumulates with In-Network.** | | | | | | |
| The plan documents under links on the Benefits Home page, located at www.maricopa.gov/benefits or ebc.maricopa.gov/hr/benefits, provide a complete description of benefits. These official documents govern if there is a discrepancy between the information on this comparison spreadsheet & the plan documents. | | | | | | |
| *Revised 09/20/2003* | T:/Benefits/Van_Go/Benefit Comparison Grid/09202003.xls | | | | | |